STRATEGIC PLAN

MENTAL HEALTH CENTER
OF NORTH CENTRAL ALABAMA, INC.
2010-2011

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Purposes of the Strategic Plan

1. To provide direction and guidance for the leadership of the Mental Health Center, including the Board of Directors.

2. To define the Mental Health Center to our various constituencies, including purchasers of service and regulatory groups.

3. To serve as a training manual for employees of the Mental Health Center.

THE STRATEGIC PLAN
REVIEW

This document will be reviewed at least annually.

Board Review:_____
President/Date

I. WHO WE ARE

I.A. Our Corporate Status

The Mental Health Center of North Central Alabama (MHCNCA) is a public, non-profit corporation, incorporated under Act 310 of the Alabama Legislature.

1. We are a PUBLIC organization. The MHCNCA is incorporated for a public purpose, to serve a public need. (Most non-profit organizations are privately incorporated, e.g. churches, advocacy organizations, fraternal organizations, etc.) We are considered quasi-governmental since we are established by local governmental entities: Lawrence County, Limestone County, Morgan County, City of Athens, City of Decatur, City of Hartselle and City of Moulton.

2. We are a NON-PROFIT organization. That is, the MHCNCA is incorporated for charitable and beneficial purposes without the intent of making profits to be distributed to its owners or shareholders.

3. We are a Corporation. While we are a public, service agency, we are none-the-less a corporate entity. We have a corporate legal status and we operate as a business.

4. We are a local organization. We are governed and operated by a locally appointed Board of Directors. We belong to the community of North Central Alabama. We are not a state agency.

The Board of Directors: 21 directors are appointed by the local governmental bodies previously listed. They are volunteers who are charged with the legal responsibility to oversee the MHCNCA. The Board employs an Executive Director who is responsible for the operations of the MHCNCA. The Board meets every 3rd Thursday at 12:00p.m.

I.B. Our Mission

The Mental Health Center of North Central Alabama is committed to providing the highest quality treatment, education and assistance to people affected by mental health and substance use issues.

I.C. Our Vision

Our vision is to be **the** premier provider of community mental health in Alabama. The foundation of our vision is customer satisfaction, responsiveness, accessibility, quality of care, expertise, adaptability and innovation.

I.D. Our Customers

We are here for our customers and we cannot exist without them. Therefore we focus our philosophy, our structure and our resources on them. While it can be quite difficult to manage increasingly limited resources to help an increasingly complex market of customers, we are committed to that task. Even if we cannot satisfy all of the needs and wishes of our customers, we will do what we can.

Types of Customers:

Our customers are of four types: clients, constituents, competitors and co-workers.

1. Clients: Clients are **the** ultimate customer and the reason we are here. Their well-being is the primary focus of our efforts.

2. Constituents: Constituents can be individuals or groups who play a vital role in our activities and who have the ability to affect our operations.

3. Competitors: Competitors are other providers who serve the same markets we serve. We treat competitors with courtesy and respect.

4. Co-workers: Co-workers are internal customers to one another. Our co-workers deserve the same consideration we extend to our external customers. We will give quality services or products to one another.

Targeted Customers: Purchasers of Services (Prioritized)

The MHCNCA seeks customers who want to purchase services that are consistent with our organization mission and vision. These purchasers make services possible where otherwise there might be no services. Purchasers of services, therefore, are the critical link between community needs and the ability of the MHCNCA to meet those needs. The prioritization of these critical customers is as follows:

- Large volume contract purchasers. Examples: Medicaid, Alabama Department of Mental Health, business and industry, and Medicare.

- Agencies and organizations with critical masses of persons needing services who have purchasers for those services, and who can be served on the agency's site. Examples: schools and nursing homes.

- Key individual referral sources. Examples: physicians, and business that contract with the MHCNCA.

Our Targeted Categorical Client Populations (Prioritized)

Purchasers of service determine the client populations the MHCNCA serves since it is they who provide resources to support the services. Those categorical populations also must be consistent with the mission of the organization. They are prioritized:

- Adults with serious mental illnesses
- Children with severe emotional disturbances
- Geriatric adults with serious mental illnesses
- Adults with substance abuse issues
- Adults and children with emotional problems
- Other

Situational and Circumstantial Priorities: Without regard to categorical population or purchaser priorities, situational and circumstantial priorities are as follows:

- Persons in crisis, with a mental health condition, which could result in danger to self or others, or to property
- Persons discharged from a state psychiatric hospital
- Persons in acute distress, with a mental health condition, which could lead to psychiatric hospitalization
- Persons with mental health problems that significantly and negatively affect their life functions

When needs assessments reflect a population in need of services but there are no resources to provide them, the MHCNCA fulfills its mission by actively seeking sponsors to purchase services on behalf of those in need. When persons seek services from the MHCNCA, which for whatever reason we cannot deliver, we refer them to suitable alternatives in the community.

Demographics of Populations by County:

For the fiscal year 2009 – 2010, the Mental Health Center, NCA served 5,266 persons. Of this number, 3,675 were adults (70%) and 1,591 were children (30%).

Morgan County accounted for 61% of all clients served; Lawrence County accounted for 14% of all clients served and Limestone County accounted for 25% of all clients served.

Racial demographics of clients served for this time are as follows: 80% white; 17% African American; 2% Multi-racial and other groups that are less than one percent. This racial make-up is consistent with the racial make-up of the north central Alabama community.

Other facts about those served during FY 09-10:

(a) Of the total number served, 55% were female and 45% were male.
(b) Approximately 68% of all persons served during this time had an SMI/SED diagnosis (coded SMI/SED)
(c) Only approximately 13% of all adults served held full-time employment.
(d) Approximately 20% of all adults served were unemployed (excluding persons who are retired or incarcerated).
(e) Approximately 4% of all adults served are veterans.

(f) Approximately 73% of persons served are dependent upon public assistance, disability, or other form of financial assistance to meet their basic financial needs.
(g) Only 56% of all adults served during this time had a high school diploma\ GED or higher education.

Community Needs/Service Priorities

(a) How needs are assessed:
MSHIP; Client Satisfaction Survey; Board of Directors; Children's Policy Council; NAMI; Multi-needs Teams, Other interagency groups; Advisory Committees; QA/PI Client and Family Feedback Process; Consumer Groups, Human Rights Committee

(b) Greatest area of unmet needs:

Of the many unmet needs for this population, perhaps the most pressing is the issue of homelessness. Existing homeless shelters in north central Alabama lack the personnel, training and resources to sufficiently serve persons with mental and co-occurring illnesses. The bizarre behavior, delusional thought processes and dramatic emotional swings displayed by many with an SMI diagnosis are simply beyond the scope of organizations not established and trained in mental health services. Homeless, mentally ill persons are often placed in jail because of their bizarre behavior and substance use and are often committed to psychiatric hospitals because they have no other place for agencies to refer them.

The Mental Health Center of North Central Alabama has, for over the past 25 years, operated transitional residential programs for adults with serious mental illnesses. Fifty-four (54) transitional beds are currently provided year round. Services provided for persons residing in one of our transitional facilities include: psychiatric treatment and medication, day programming, individual and group counseling, case management, limited transportation and other services as needed. During the fiscal year 2009-2010, approximately 77 different clients were housed at one of our residential programs.

To further address the plight of homeless persons with a SMI diagnosis, the Mental Health Center of NCA submitted a Permanent, Supportive Housing proposal to the Housing and Urban Development as a member agency of the North Alabama Coalition for the Homeless. This project provides permanent housing for up to 10 persons with a SMI diagnosis. 11 people served during 2009-2010.

Additionally, a HUD 811 proposal for a permanent housing facility in Lawrence County for persons with a SMI diagnosis was granted (The Village) with 10 units and an on-site manager. 10 units – on-site manager.

I.E. Our Values and Philosophy

A system of care is based on values and beliefs, whether written or implied. The following statements reflect the values and philosophy of our organization. It is important that every employee understands and embodies these values if the organization is to fulfill its mission. The centerpiece of our values is quality to the customer.

1. Satisfaction is the hallmark of quality. We believe that satisfaction with services is the best measure of quality. In the absence of more clearly delineated measures of quality, the primary measure will be customer satisfaction.

2. We believe that our first obligation to our customers is to provide quality services today and improved services tomorrow.

3. We believe quality and productivity are essential. It is the quality of our productivity that matters.

4. Quality can be caused and therefore it can be managed. It doesn't just happen; it is built into the design of our products and processes.

5. The best way to ensure quality is to continually improve our processes.

6. In order to stay in business in an increasingly competitive market, we must become more attractive to our customers. Therefore, we will continue to develop and provide services to meet their needs.

7. A key element to successful performance is for every employee to assume responsibility for the mission and performance of the organization.

8. Prevention of errors rather than correction is the best way to achieve quality outcomes.

9. The continual improvement of staff knowledge and skills is essential to performance improvement. This will be accomplished through an ongoing process of training.

10. The first job of management is leadership. We will place in management positions those persons who understand the job and can effectively lead.

11. We believe that our staff take pride in their work and want to contribute to improvements in quality and productivity, which comes from having the tools to do their jobs effectively.

12. We will continue to encourage cooperative efforts by eliminating barriers that separate staff.

I.F. Code of Ethics and Standards of Conduct

The organization's ethical standards permeate all official board-approved documents, such as the Strategic Plan, Operations Manual, Personnel Policy Manual, Corporate Compliance Plan, Performance Improvement Plan and Board By-Laws.

We believe that employees and Board members reflect their commitment to the organization's ethical standards through their knowledge and understanding of those documents and in their compliance with the values and principles expressed therein.

The following summary statements are principles upon which all others are based.

1. We believe it is an ethical requirement that all persons associated with the organization comply fully with all laws that are relevant to our practice.

2. We believe that it is an ethical responsibility of employees and Board members to share a commitment to our organization's mission and goals, its values and principles and its policies.

3. We believe that all clients, employees, vendors, payers and visitors deserve to be treated with dignity, respect and courtesy.

4. We believe that all employees share the responsibility for the treatment and satisfaction of all Mental Health Center clients while always respecting and protecting their rights.

5. We believe that the organization, through its employees, shall fully inform our clients of their rights and obligations associated with their care and to inform them of risks and benefits associated with that care.

6. We believe that it is our ethical duty to do everything reasonably possible to serve those in need of our services; therefore if a person requests services, which we cannot provide, or which he/she cannot or will not accept, we will provide referrals to appropriate alternatives.

7. We believe that the provision of care should be of comparable quality regardless of the setting in which that care is provided.

8. We believe that the organization must respect the client's right to confidentiality and to protect against unlawful or unethical disclosure of confidential information.

9. We believe that we should provide only those services and use only those techniques for which we are qualified by education, training and/or experience and our marketing efforts will represent us accordingly.

10. We believe that employees must respect the clients of the Mental Health Center, and therefore will refrain from attempting to impose their own value systems on the clients, and from engaging in any activity that could be construed as exploitation of clients for personal gain.

11. We believe that employees should always uphold the integrity of the Mental Health Center, their co-workers and payers, by billing honestly, making only truthful representations and refraining from self-serving solicitations.

12. We believe that employees owe a greater allegiance to higher ethical standards than to compromising relationships; therefore we are all obligated to report any unethical or illegal behavior to a supervisor or other official.

13. We believe that, in many ways, other health care providers and educational institutions are our partners in carrying out our mission and therefore deserve our respect and cooperation.

Board President

Executive Director

The Code of Ethic applies to all employees, board members, students, independent contractors, temporary staff and volunteers.

I.G. Organizational History

The Mental Health Center has provided mental health services to the people of Lawrence, Limestone and Morgan Counties for more than thirty years. The ongoing interaction and mutual respect between our organization and our community have resulted in continual organizational change in response to shifting community needs, which are frequently defined by the payer. Changes can be characterized in five ways:

- Growth: The MHCNCA has increased service capacity in response to the consistent growth in demands for service by the community.

    - 1967-68, the North Central Alabama MH Board served 509 clients with 2,184 service units
    - 1977-78, the North Central Alabama MH Board served 2,000 clients with 11,327 service units
    - 1987-88, the North Central Alabama MH Board served 2,898 clients with 66,384 service units
    - 1997-98, the MHCNCA served 4,198 clients with 124,574 service units
    - 1999-2000, the MHCNCA served 4,539 clients with 115,485 service units
    - 2000-01, the MHCNCA served 4,641 clients with 127,393 service units
    - 2002-2003, the MHCNCA served 4,336 clients with 142,170 service units
    - 2003-2004, the MHCNCA served 4,763 clients with 159,587 service units
    - 2004-2005, the MHCNCA served 4,812 clients with 154,695 service units
    - 2005-2006, the MHCNCA served 4,865 clients with 169,072 service units
    - 2006-2007, the MHCNCA served 4,801 clients with 164,827 service units
    - 2007-2008, the MHCNCA served 4,753 clients with 156,157 service units
    - 2008-2009, the MHCNCA served 4,988 clients with 185,202 service units
    - 2009-2010, the MHCNCA served 5,266 clients with 189,536 service units

- Changes in the revenue stream: Over the years we have evolved from an organization that was wholly dependent on federal grants, through a transition period of being almost totally dependent on state funding, to the current situation of earning a substantial percentage of our revenues through fee-for-service agreements and self-pay.

- Continuity of leadership: In our forty years, we have had strong continuity of staff leadership and board oversight. During that period the Mental Health Center has had 5 Executive Directors. Board Members serve 6-year terms.

- Intensive interventions: with the strong emphasis on community care for persons with serious mental illnesses and children with severe emotional disturbances, our base client population has demanded, and we have delivered, more intensive interventions to fewer, more severely disturbed clients. Today over 60 % of our clients are those severely disturbed persons who have absorbed a disproportionately higher share of service units. Other categorical client populations that are growing include those with substance abuse issues, geriatrics and severely emotionally disturbed children.

- Increased competition: The Mental Health Center is in one of the most competitive arenas in the State of Alabama, and we have continued to improve the quality of our services, the efficiency of our delivery system, and the attractiveness of our array of services to thrive in a competitive environment.

- The Mental Health Center currently has 186 staff working in 15 MHCNCA locations as well as in schools, nursing homes, and Juvenile Courts.

I. H. A Historical Sketch:

1967 -The Board was incorporated under the name of The North Central Alabama Mental Health Board, Inc. It was originally incorporated as a private non-profit organization.

1968 -The first Executive Director, David Loiry was employed and the Mental Health Center began providing services.

1971 -The second Executive Director, Preston Bryant, was employed.

1974 -The third Executive Director, James Meherg was employed.

1978 -The fourth Executive Director, Thomas Salter, was employed.

1982 -The Mental Health Center changed its corporate status to public non-profit.

1996 -The name was changed to The Mental Health Center of North Central Alabama, Inc.

1999 -The Mental Health Center employs 165 staff, serves more than 4000 clients annually, delivers more than 122,000 units of service and generates over $6 million in revenues. Marie Hood was named the fifth (and current) Executive Director.

2001-The Mental Health Center employs 181 staff, serves 4,641 clients annually, delivers more than 127,720 units of service and generates over $7,365,323 in revenues.

2002- The Mental Health Center employs 185 staff, serves 4,442 clients annually, delivers more than 133,491 units of service and generates over $7,439,631 in revenues.

2003- The Mental Health Center employs 175 staff, serves 4,336 clients annually, delivers more than 147,170 units of service and generates over $7,571,981 in revenues

2004- The Mental Health Center employs 175 staff, serves 4,763 clients annually, delivers more than 159,587 units of service and generates over $7,814,686 in revenues

2005- The Mental Health Center employs 175 staff, serves 4,812 clients annually, delivers more than 154,695 units of service and generates over $7,740,643 in revenues

2006- The Mental Health Center employs 171 staff, serves 4,865 clients annually, delivers more than 169,071 units of service and generates over $8,647,566 in revenues

2007- The Mental Health Center employs 187 staff, serves 4,801 clients annually, delivers more than 148,018 units of service and generates over $8,698,768 in revenues

2008 - The Mental Health Center employs 177 staff, serves 4,753 clients annually, delivers more than 156,157 units of service and generates over $9,479,027 in revenues

2009- The Mental Health Center employs 186 staff, serves 4,988 clients annually, delivers more than 185,202 units of service and generates over $9,971,416 in revenues

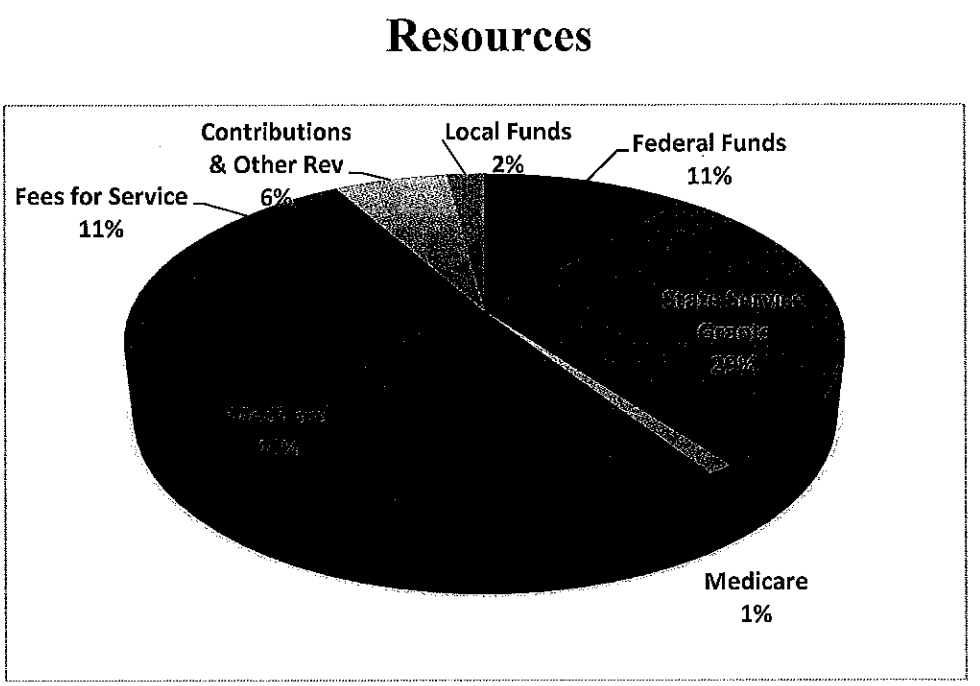
I.I. Our Resources

As a public non-profit organization, we have resources for one reason: to carry out our mission to do what we can to provide treatment, education and assistance to people affected by mental health problems. Any resources we earn, or are given, must be used to fulfill that mission. We differ from for-profit organizations in that we do not help people in order to generate revenues; we generate revenues in order to help people.

To meet all of the diverse needs of a diffuse and complex market would require an equally diversified and unlimited array of resources. Such a resource pool is not feasible. Our response is to search continually for payer sources to enable us to serve the enormous needs of our community. Where there is a need without resources to pay for the services, there can be no service; therefore, we continually seek resources.

The most important resource we have is our people. It is our people who translate tangible, financial resources into customer satisfaction.

The sources of our financial resources are graphically displayed below:



II. WHAT WE LOOK LIKE

II. A. Our Concept of Structure

Every organization must have structure to exist. Philosophy and values without structure are scattered and ineffective. If quality to our customers is to be ongoing, it must be built into the structure of the organization.

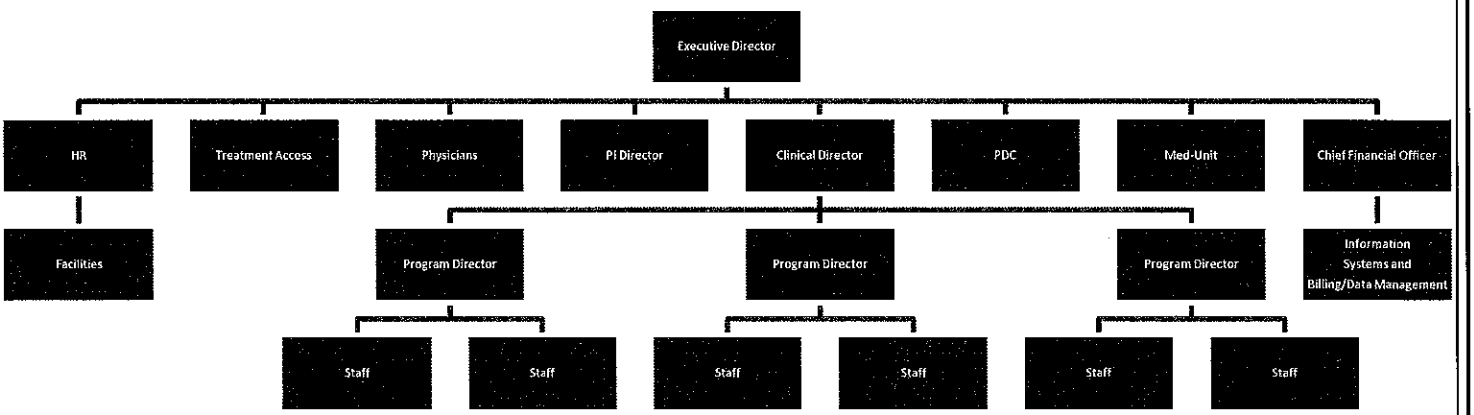
We have structured our organization in a way that allows us to:

- be consistent with our mission and vision;
- focus on our customers;
- be consistent with our philosophy and values;
- encourage teamwork;
- continually improve our processes, our products, and our services;
- allow all levels of employees to participate in decision-making and
- single point of contact.

II. B Types of Structure

There are three types of structure within our organization. Our ability to achieve our mission depends on how well these systems work together.

1. Vertical Structure: The obvious structure is the vertical organizational structure. It has lines of authority and supervision, formal work groups and a well-defined hierarchy of leadership. This type of structure is displayed graphically in the line-and-box vertical organization chart, illustrated below.



2. Horizontal Structure: In our organization, there is a second structure, which is also formal and defined. It has a line of authority, a hierarchy of leadership and communication channels; but is not based on supervisory authority. It depends on cooperation and commitment to a common mission for its effectiveness. It is based on teams and task groups which are comprised of employees from all across the organization and whose leaders may or may not be supervisors from the vertical structure.

   General oversight of the horizontal structure is the responsibility of the Steering Team through the Performance Improvement Director.

   A. The Purpose of the Horizontal Structure is:

   - To foster interdependence among staff and teams;
   - To provide structure for continual quality improvements;
   - To engage every employee, as well as clients and constituents, in a partnership for generating improvements;
   - To nurture and develop our staff;
   - To provide constructive channels of communication and interaction for staff across the organization.

B. PI Teams: The basic unit of performance in this horizontal structure is the performance improvement team (PI Team). PI Teams are cross functional. They are groups whose purpose is to improve processes and products that extend beyond any one-work group's sphere of control. These teams are small, usually comprised of 4 to 8 staff. Decisions are generally made by consensus; and leadership may be assigned or selected by the team. PI Teams may be standing and ongoing, or ad hoc and temporary. The Steering Team establishes and oversees the work of standing PI Teams, and some of the ad hoc teams.

3. Task Teams: The Steering Team or any PI Team may form a task team from outside the PI Team membership to achieve a sub-goal, or task, and report back to the parent team. The task is, by definition, time limited with a specific outcome that feeds a larger goal.

4. Processes: A process is a stream of activities that results in a service or product. It may include few or many steps and involve only one or several people. For example, the billing process involves a client, a clinician, one or more program clerks, Billing and Data Management, and Business Office. Several pieces of paper and computer products flow down this stream, which winds its way across teams, work units and geographical lines. Since the process flows across vertical structure lines, it necessitates cooperation of co-workers who normally belong to different work groups. Our system is made up of hundreds of such processes. For this complex system to operate smoothly, co-workers must recognize their interdependence with one another and respect their internal customers, both upstream and downstream. The horizontal structure enables this interdependence by linking co-workers who work on the same process into horizontal teams. An improvement in any step along the process subsequently results in an improvement in its service or product. Therefore, the horizontal structure is the way to facilitate continual improvement of all processes, products, and services. While changes in policies require Steering Team and/or Board approval, process improvements may be initiated and implemented by teams and work groups provided that the improvements are coordinated up and down the process stream, under the direction and oversight of the Steering Team.

5. Advisory Councils: These councils are set up to coincide with constituency groups, with representatives of consumers, family members, agency heads and other stakeholder. Advisory Councils may be organized for children's services, mental illness, substance abuse, geriatrics, or human rights. The council members are approved by the Board of Directors; they provide customer input and feedback for the respective service units.

II. C. Steering Team

The responsibility for coordinating and overseeing this complex structure rests with the Steering Team. The Steering Team is comprised of the Executive Director, Medical Director (ad hoc), Clinical Director, Chief Financial Officer, Human Resources Manager and Performance Improvement Director. Each member is responsible for coordination and oversight functions in his/her respective stream and working within the steering structure to inform and organize for the benefit of the whole organization.

Specific oversight functions of the Steering Team include:

- Strategic Planning
- General direction and oversight to vertical work groups and horizontal teams
- Resource allocation
- Utilization of resources and monitoring of service effectiveness
- Compliance with laws and standards which affect the organization's ability to function (including Alabama Department of MH regulations, Service Delivery Manuals, contract, and applicable local, state and federal laws and regulations)
- The organization's Corporate Compliance Plan (The Steering Team serves as the Corporate Compliance Team)

It is at this point where the vertical and horizontal structures are integrated and coordinated with external constituencies.

II. D. Family - Client Involvement

If our organization is to respond effectively to the needs of those who are affected by mental health problems, those people must be involved in an integral way in the planning and performance of all relevant functions. Clients and their families are built into the heart of our operations.

- Treatment and Care: Clients and their families participate actively with their clinical staff in the planning process of their treatment and care. Treatment goals are their goals, and the process is driven by their needs as evidenced by the Person Centered Treatment Approach.

- Satisfaction Surveys: Survey forms are mailed to a sample group of clients on a monthly basis with self-addressed stamped envelopes for ease of return. Responses are reviewed and reported monthly. Reports are submitted to staff, Board of Directors and others as requested. Appropriate follow-up actions are taken.

Client and Family Feedback Survey: As a part of the QA/PI process, Client and Family Feedback Surveys are mailed each month to those clients whose records are reviewed by the team. Returned surveys are reviewed by the PI Director for needed follow-up and performance improvement or other team action. The Mental Health Center of North Central Alabama, Inc believes that it is important to get input from the families of our clients, as well as, the clients themselves. Family Satisfaction Survey boxes along with surveys are placed in each location's lobby. Each month the surveys are collected. If there is a survey that needs immediate attention, the Performance Improvement Director will take action to resolve the problem if feasible. Quarterly this information is analyzed and forwarded to the QA team for input into the QA/PI Process. Also, the information can also be routed to any team or program that has the ability to improve the process or function to which it pertains. When relaying data or information to teams no client identifying data will be forwarded. If it is found that the client/family wants direct feedback, and if there is consent to follow up, then the identifying information will be given only to a supervisor or a member of management with the right or need to know.

We also participate in the Consumer and Family Satisfaction Survey distributed by the Alabama Department of Mental Health.

- Internal Client Councils: Each county center for the seriously mentally ill has a client council, which meets quarterly to provide input, feedback and guidance to staff. Other programs also sponsor internal client councils appropriate to their client populations.

- Advisory Councils: As previously described, there are Community Advisory Councils for discrete consumer populations (e.g., Mental Illness, Substance Abuse, Geriatrics, Children, Human Rights). Each council is comprised of customers - including primary clients and family members - of that specific client population. These councils generally meet four times a year.

- Community SMI Family - Consumer Advisory Meeting: Our area chapter of the National Alliance for the Mentally Ill (NAMI) meets monthly. The MHCNCA Executive Director and/or Clinical Director attend meetings and address issues defined by the NAMI members and by the MHCNCA.

- The MHCNCA Board of Directors: The Board of Directors is comprised of citizens who are appointed by the city and county governments to represent the interests of the broad community and to oversee the operation of the MHCNCA. Board members include clients, families of clients and advocates. All Board members participate actively in carrying out the mission of the organization.

III. WHERE WE ARE GOING

III. A. The Planning Process

Planning is an ongoing process of gathering information, interacting with customers, establishing goals, implementing services and reviewing performance data, making corrections and redirecting when needed.

The Steering Team is responsible for guiding the Strategic Planning process, subject to the approval of the Board of Directors. While the process is an ongoing cycle, it is easier to understand if it is described in a linear progression, using the fiscal year as a framework. The planning process itself follows the PDCA model.

1. PLAN: The "Plan" component of the planning process begins in May each year, when the Steering Team assimilates community needs assessments and internal information to formulate direction and priorities.

May: The Steering Team engages in formal planning sessions, in which the team reviews the organizational mission, vision, customers, values, and philosophy. During these sessions the Steering Team establishes the Focus Area for the coming year, identifies Strategic Goals and sets the time-line for engaging all stakeholders in the planning process.

The process for setting priorities is as follows:

- The Steering Team reviews input information from available sources, including staff from both vertical and horizontal teams, advisory councils, community planning groups, the knowledge and assumptions of the Steering Team members, the Board of Directors, formal and informal consumer feedback, and payer demands and expectations.

- The Steering Team decides, through discussion and consensus, on the single major theme, or focus area, to guide further priority setting.

- Through a process of discussion and debate, and consensus building techniques the Steering Team arrives at consensus decisions regarding the selection of the critical few areas to focus our resources on for the next year.

- Through a process of discussion, the critical few areas of concerns are formulated into goal-like statements.

- Through a process of consensus building techniques, discussion and debate, the Steering Team assigns priorities to the resulting goals statement.

- The focus area in the form of goals is put in a form suitable for presentation to staff leadership and the Board of Directors.

2. DO: The "Do" component begins about June, when the broader leadership of the Mental Health Center begins the work of doing the plan development through the vertical and horizontal structures.

June - July: A leadership session is provided where supervisors and team leaders are briefed on the elements of the planning process, including the Focus Area (s), Planning Assumptions, and tentative organizational goals

and financial parameters. Conversely, supervisors and team leaders provide input regarding their resource needs (financial, staff, facilities, information, etc.).

June - August: All work groups and teams develop a plan for the upcoming year to ensure that team and unit goals are derivative of and contributory to the organization's goals. Clinical Director coaches Program Directors; Performance Improvement Director coaches PI-Team Leaders; and Chief Financial Officer coaches administrative units and works with program directors and team leaders regarding budget development.

3. CHECK: Early in August, the Steering Team reports to the Board of Directors as a checkpoint in the planning process.

August: Extended work session for the Board of Directors to review the work-in-progress. This intensive planning may include the following topics: presentation of program overviews; review and discussion of needs assessment and planning assumptions; Focus Area(s), goals, and specific initiatives. The Board gives official "go ahead" to proceed with the planning.

September: Leadership meets to share goals for the purpose of coordinating efforts. The Steering Team trains all supervisors, PI Teams Leaders, area coordinators, and other key staff regarding Strategic Plan and other corporate plans.

September: The Board of Directors approves the final plan.

4. ACT: On October 1, the plan is implemented.
This process is self-renewing in that input and feedback are constantly being received from customers, staff, Board, advisory councils and others. For example:

1. Advisory Councils meet at least three times a year. The minutes of their meetings are circulated to the Steering Team, Board of Directors and appropriate programs. Recommendations are passed along to appropriate teams and work groups.

2. All PI Teams route their minutes, via internet, to the Steering Team for the purpose of coordination and oversight. This information feeds into the planning process.

3. Performance and financial reports are broadly circulated and reviewed, and analyzed on a monthly basis by the program directors and the Steering Team.

4. Satisfaction is assessed on an ongoing basis. Examples of the assessment include audits, feedback, an increase in contracted services and new contracts with county agencies.

All of these sources are fed into the ongoing planning process and corrections are made in the plan as needed. Any element of the planning process, or of the plan itself, is subject to change as indicated by changes in the environment, payer demands, consumer needs, crisis situations feedback from monitors, or unforeseen opportunities. In such cases, the Steering Team reviews data, decides on an action plan and implements the plan.

III. B. Our Assumptions about the Future 2010 - 2011

The planning assumptions reflect the information received from such sources as our advisory councils, consumer councils, community constituencies, contractors and other revenue sources, healthcare sector literature, and feedback from client satisfaction surveys. The assumptions reflect the consensus of the Steering Team relative to the future of our organization, and become a driving force in our planning.

Assumption #1: We will face strong competition for our traditional markets.

Action Implications:

1. We must know the competition.
2. We must exceed the competition's quality.
3. We must remain financially stable.
4. We must diversify our markets.
5. We must better define who our customers are, and who they should be.
6. We must continually identify and reduce waste.
7. We must network with community providers to meet competition more effectively.

Assumption #2: Money for Mental Health Care will be more difficult to obtain.

Action Implications:

1. We must be more efficient, creative and innovative in service delivery systems and in use of staff time.
2. We must be willing to divert our resources to act on opportunities.
3. We must be aware of where, how, and if, it is cost effective to access resources.

Assumption #3: The mental healthcare system will continue to be payer driven.

Action Implications:

1. Structure the service delivery system around customer needs while satisfying payer demands.
2. We must have a mechanism to know if we are satisfying our payers.
3. We must educate caregivers and clients regarding the role, benefits and limitations of their payer services.
4. We must train staff to work in a payer-driven system.
5. We must promote ourselves.

Assumption #4: Desirable employees will be those who are flexible, adaptable and versatile with marketable skills.

Action Implications:

1. Improve staff skills through targeted training.
2. We must develop leadership skills among staff.
3. We must educate staff about why changes occur, and support them during change.

Assumption #5: Based on technological and medical advances mental health care, as we know it, will continue to evolve.

Action Implications:

1. We will do more research and development to keep abreast of cutting edge technologies.
2. We will put resources into technological and medical advances.
3. We will utilize more non-traditional forms of services.
4. We will explore other funding services i.e. grants.
5. We will explore different corporate configurations/structures.
6. We will acquire state of the art equipment.

III. C. Strategic Goals 2010-2011

Goal 1: Ensure customer satisfaction by continuously improving the quality of services provided.

Goal 2: To insure our future we will continually explore alternatives to traditional services, while at the same time improving our core services.

Goal 3: Continue to educate the community on who we are and what we do.

Goal 4: Maintain the financial stability of the organization by effectively using all resources in an efficient manner. Acquire and develop new revenue streams.

Goal 5: Continuously evaluate and improve quality via systematic (methodical, orderly, organized and logical) processes.

Goal 6: Continue to explore the latest technology to improve the efficiency of the organization. Research and develop an electronic medical record implementation plan.

IV. BOARD INFORMATION

MENTAL HEALTH CENTER
OF
NORTH CENTRAL ALABAMA, INC.
2010-2011

OFFICERS

Allen Jeffreys, President
David Fuller, Vice-President
Billy Hudson, Secretary
Carolyn Stair, Treasurer

EXECUTIVE COMMITTEE (9)

Edith Bennich
Blythe Bowman
David Fuller
Billy Hudson
Allen Jeffreys
Don Osborne
Lisa C. Payne
Franklin Penn
Carolyn Stair

MENTAL HEALTH CENTER
OF
NORTH CENTRAL ALABAMA, INC.
2010-2011

BOARD MEMBERS

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